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Orsett Psychological Services
PO Box 179
Grays
Essex
RM16 3EW

orsettpsychologicalservices@phonecoop.coop

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The Psychology of Childhood in the Non-Western World: The "Normality" of Maltreatment and Neglect?

INTRODUCTION

Child abuse, maltreatment, and neglect are important topics in the psychology of childhood. Attempts to categorise and define the terms include physical injury, sexual abuse, and emotional abuse (Brewer 2004a). While Browne and Herbert (1997) used four levels of child maltreatment and neglect from "less severe" to "life-threatening".

For example, "life-threatening" neglect includes persistent unavailability of the caretaker, the child left alone often, and frequent illness because of poor hygiene (Browne 2002).

The criteria used to measure the level of maltreatment and neglect are generally helpful, but there are of limited use outside the West (rich countries). The behaviour described as "life-threatening" neglect above is common outside the West. This is not that all parents in poorer countries are bad or abusive parents, but that the situation of life is very different. Frequent illness and poor hygiene are a product of poverty, and parents may be away looking for food (or work).

By Western definitions, most children in poorer countries are maltreated or neglected. But care needs to be taken because much of this behaviour is a product of the world system (Gans 1973) rather than of "bad" individuals most of the time ⁽¹⁾.

Unless psychology is to remain pre-occupied with itself in the West, it needs to understand the experiences of children (and adults) around the world. This article looks at childhood experiences which are not necessarily unique to poorer countries, but are much more common - child labour, poverty and malnutrition (disadvantage), and living in armed conflict situations.

Psychology textbooks generally pay little attention to these issues. For example, in the classic US textbook "The Developing Child" by Helen Bee (1995a), there are four pages on poverty (in the US), and one study reported on work ⁽²⁾ in 590 pages ⁽³⁾.

CHILD LABOUR

The world of childhood is regarded as a time of innocence to be protected from the brutal aggression of the real world; a period of latency during which a child needs shelter while growing up until he or she is finally ready to confront reality (Schlemmer 2000 p4).

For child labourers around the world, their experiences are far from this picture.

Generally there are a number of types of child labour (Morice 2000):

- i) Within the family including children who accompany their parents to outside work;
- ii) Children "placed" outside the home including bonded labour and apprenticeships;
- iii) Child wage-earners;
- iv) Street-children (who have usually left the family) ⁽⁴⁾.

Yet, in some cases, rather than being passive exploited individuals, "there are many working children who have become their families' de facto breadwinners, and who are perfectly well aware of and derive legitimate pride from this fact" (Schlemmer 2000 p4).

Another twist to the issue of child labour is that parents may be "grateful" to an employer who keeps their child "off the street", and gives an "apprenticeship" (Schlemmer 2000). The idea of labour for the child's own good is also evident in the family - the ubiquitous caring for younger siblings by girls, for example. "The brutality of exploitation may be found within as much as outside the domestic environment" (Schlemmer 2000 p10). This, and other activities like housework or chores, is child labour in one sense ⁽⁵⁾.

The International Labour Office (ILO) has attempted to deal with the ambiguities of child labour by making a clear distinction between "children working in socially and personally useful ways - working for pocket money, doing household chores, helping in the family business during the school holidays - and children whose working conditions should be regulated or eliminated" (Black 1993 p16). Alvim (2000) called the latter the "socially invisible".

The greatest concern is over those children "prematurely leading adult lives" and working in conditions which are damaging to "their physical or mental development" (Black 1993). The effect upon the child's development seems to be key as to whether the labour is right or wrong.

But there is a contradiction again: "Work can just as easily provide children with an opportunity to escape the violence of a broken home; or at least to stand up for their right to choose, their individuality, and sense

of personal responsibility within the family group" (Schlemmer 2000 p10).

Stella (2000) noted that historically with industrialisation, and children moving to work in factories, there was such an ambivalence. The unpleasant working conditions of factories compared to agricultural activities, against earning a wage and release from "the constant control and authority of a father/master".

Child labour is also a risky business. Taracena and Tavera (2000) interviewed thirty-six child workers in Mexico city in four types of employment, and found that the risks for child workers were very high in some cases (table 1).

TYPE OF WORKERS:	SUPERMARKET	SALES	SERVICES	PERFORMANCE
DESCRIPTION	Help shoppers pack up goods and take to car park for tips	Selling chewing -gum, food, drink	Shoeshine, car wash, windscreen -cleaners, porters	Singers, musicians, fire-eaters
MAIN AGE (yrs)	14-15	8-15	12-15	9-14
RISKS	None	Pollution Accidents - some	Pollution Accidents - some Violence - all	Pollution Accidents Violence Drugs - all
FUTURE PLANS	Mostly education	Some education	Little education	None
FAMILY	Not depending on income	Depending on income	Depending on income	Live full-time on street, broken away from family

(After Taracena and Tavera 2000)

Table 1 - Types of employment of child workers in Mexico city.

Child workers may face stigmatization, like the streetworkers of Mexico city. Taracena and Tavera (2000) analysed 37 newspaper and magazine articles about how child streetworkers were viewed in Mexico. The press tended to describe the children negatively: for example, exaggerating the extent of drug abuse.

It is the performance-type child streetworkers who are most stigmatized by the media. "Little is said about the vast numbers who, notwithstanding difficulties, arrange with their families to have a job to enable them to contribute to the family budget; who still go to

school; who are ambitious to master a trade; who learn how to make a living on the streets, with its rules, its culture and demands; who are prepared to struggle there day in day out to survive" (Taracena and Tavera 2000).

The ideal is that children attend school (and gain qualifications), and then move into work as a young adult. But to be attractive to parents where income is short, schooling must be free, and "equip the child for later life".

From a Western perspective, child labour automatically seems exploitative, and undesirable for children, but it is only a link in the chain of exploitation within "consumer capitalism" ⁽⁶⁾ or global capitalism ⁽⁷⁾ that exists today. While other chains of exploitation exist nearer to home, then child labour is a long way from being dealt with in this world:

Underage labour helps perpetuate the existence of an illiterate, overexploited, prolific and delinquency-generating sub-proletariat. It stocks and replenishes an abundant reserve of deskilled, hard-working and insecure labourers who, unaware of their rights, are cheap and easy to exploit
(Meillassoux 2000b p315).

The chain of exploitation shows itself, for example, in adolescent workers in Britain. Some work is viewed specifically as "children's work" (eg: delivering newspapers), but other work is directly competing with adult workers (eg: in restaurants and shops) (Lavalette 2000). Whichever type of work is performed, the wages are lower than adult ones, and the adolescents' labour is "devalued and cheapened".

Elson (1982) explained this situation as due to adolescents' disadvantaged position in the age hierarchy of society: "a system of seniority in which those in junior positions are unable to achieve full social status in their own right" (p491). In other words, the labour market is structured in such a way to limit the opportunities of adolescents (and female) workers. It is socially constructed that way to benefit certain groups in society.

The consumer is so far removed from the producer in the chain of production in the global economy that there is no meaning attached to how or who produces the good (Brewer 2001b). The historical relationship between craft or skilled worker who made the product (and thereby attached part of themselves to their creation), and the person who consumed that creation is gone. In the past,

the worker and consumer may well have known each other. Thus now the "fact that children are being exploited to death in the gold mines of Peru means nothing to the affluent classes speculating on the napoleon or adorning themselves with jewellery" (Meillassoux 2000a p42).

But "Western society is so locked into production and consumption systems that replacing these systems implies destruction of capitalism" (Gupta 2001 p74).

Within the "global free market" that is advocated today by the West, any country or economy can compete to produce goods to sell anywhere in the world. If that country is "economically successful", then it can benefit from selling its goods, so the argument goes. But around the world, it is the cheapest goods that sell to the West, and child labour is cheap (or child slavery even cheaper).

There are doubts as to whether free market economics works in theory, but the current global system is not based upon fairness and equality in competition to start with ⁽⁸⁾. Shutt (2001) argued that a key to improving the position of poorer countries in the world is for world trade to be co-operative rather than competitive.

Examples of Child Labour Situations

1. Indian Carpet Industry

Gulrajani (2000) noted that estimates of the number of children employed in the hand-knotted woollen carpet industry of the "carpet belt" of the states of Rajasthan, Jammu, and Uttar Pradesh varied between 100 000 and 300 000 in the 1990s.

Children are employed in hazardous conditions with wool-fluff in the air, and sitting for long periods in low pit looms. The dyes and chemicals are also unpleasant to the skin.

The child labourers come from lower castes and/or rural families (often landless labourers), and are signed up to work for periods of between one to ten years. The children are paid, but the wage is half or even one-tenth of the average for adults in the industry (Gulrajani 2000). The work day lasts between ten to fifteen hours, and is all seven days in the week.

There are also reports of abuse and violence. For example, a newspaper reported in September 1994 of a child carpet-worker being hacked to death in Bihar for trying to break free (Gulrajani 2000).

Gulrajani's study of the economics of the industry showed that it gained its competitiveness and "economic success" from very low labour costs. The replacement of

children with adult labourers (and adult wages) "may indeed present a serious threat to its very survival" (p63). This is "free market global economics". A whole industry (and local economies of a country) depends almost completely on exploited child labour to continue.

2. Coal-mining in Colombia

Children can start employment here as young as six years old by sorting coal and working above ground. Most of the underground work is done by children aged 12-14 years, who transport coal up to the pithead as well as actual mining. The children work through the night (1-7am), then attend school in the morning (8am-12pm), and finally work in the fields in the afternoon (2-6pm).

The poor health of these children is a major concern - parasites, calorie and protein deficiencies, anaemia, silicosis, and skin diseases, for example (Cespedes Sastre and Meyer 2000).

In some cases, work is regarded as the best way of training children because schooling is viewed as a waste of time. However, schooling is the means to reduce child labour, and Cespedes Sastre and Meyer (2000) reported an example of a project in Topaga, Boyaca to encourage school attendance. The programme is multi-faceted including access to healthcare, and is supported by the Government as well as UNICEF.

3. Coffee Plantations in Guatemala

The family of coffee-workers live and work on the big plantations, and everything is dependent upon the employment contract of the male head of the family. Wages for production are only paid to the male head, but their "production targets" assume help from the rest of the family. This has been called "super-exploitation" (Nieuwenhuys 2000).

Everything in the family revolves around the coffee production, especially harvesting. As soon as children are old enough to pick the beans without damaging the shrubs, they will be involved as "youths". Younger children ("infants"), which includes toddlers, pick up fallen beans (de Suremain 2000).

Boys work hard to prove that they can become "good coffee-workers". The socialisation process is focused upon this: a "good worker" is obedient, loyal, has stamina, and does not worry about working conditions (de Suremain 2000). The adolescents themselves see work as part of the initiation into adulthood.

The overall insecurity of the coffee-workers means that no one will question the use of child labour. Loss of job would mean loss of accommodation as well.

4. Bonded Labour

A common manifestation of child labour around the world is in the form of bonded labour ⁽⁹⁾. Basically, an adult receives a monetary loan which is repaid by the child's labour. But it is not as simple as that because the cost of the child's needs (eg: food) or fines for poor work are added to the loan ⁽¹⁰⁾. Thus the period of the bonded labour is continually increased. The debt can also be passed down through generations (Bales 2002).

Children in this situation are not necessarily pledged to do a precise job: "They must be ready to respond to the employer's every command and, in many domestic situations, particularly in the countryside, they are expected to remain available night and day to work in the fields or at the workshop, domestic service, running errands or working for a third party on the master's behalf" (Bonnet 2000 p181) ⁽¹¹⁾.

The overwhelming feeling for such children must be hopelessness because there is no escape from the daily grind, nor in terms of a future date to look forward to. Their lives are placed in "suspended animation" (Bonnet 2000).

Many of the children from bonded labour become the cheap adult migrant workers: "ready for anything, open to any sort of work and all sorts of exploitation" (Bonnet 2000 p191).

Bonded labour of children and adults is justified as local custom, caste or class differences, economics, or beneficial for both sides. Bales (2002) quoted a bond owner in India as he justified the practice: "they are from the Kohl caste... you can't just give money away.. It is a father-son relationship; I protect them and guide them" (pp73-74).

CHILDREN AND DISADVANTAGE

A key impact on children is made by poverty. Poverty is associated with poor parental mental health, greater family conflict, and negative parent-child interactions (Marks et al 2002). All of these factors affect the child in different ways.

For example, poor children are more likely to suffer from psychiatric disorders among other disadvantages compared to richer children, as shown in a study in

Ontario, Canada of over 3000 children (Offord 1991) (table 2).

	POOR CHILDREN*	MIDDLE CLASS CHILDREN
Diagnosed psychiatric disorder	31.6	13.8
Poor school performance	29.7	13.3
Social impairment	11.9	11.6
Chronic health problems	30.1	17.6
Teacher-identified conduct disorders	15.6	2.6

(* Annual family income less 10 000 Canadian dollars)

Table 2 - Percentage incidence of problems between children from poor and middle class families.

The effects of poverty are greater in the preschool years than middle childhood, and the longer the child living in poverty, the greater the negative outcomes (Brooks-Gunn et al 1999).

Research has attempted to explain the mechanisms by which poverty leads to childhood problems. It is difficult to isolate poverty from other negative variables like family conflict, but one possibility is that low income creates economic pressures leading to parental conflict. This conflict affects the child itself, or leads to inattention from parents, or produces harsh parenting, and these create the negative outcomes for the child (Conger et al 1997).

Poverty is part of a risk environment, and:
The common theme across all of these chronic risk environments is that children are immersed in a context that can be threatening, disorganised, unpredictable, harsh and conflictual (Friedman and Chase-Lansdale 2002 p267).

A variation of living in poverty is the case of children working or living on the street. Studies in a number of countries (eg: Ethiopia: Lalov 1999; Brazil: Campos et al 1994) showed that streetchildren are highly vulnerable to abuse and victimization.

Offord (2001) proposed four guiding principles for intervention programmes to reduce the effect of poverty generally on children's mental health:

i) Gradient - the relationship between family income and childhood problems is a negative correlation, and there is no income threshold. Thus any programme focused only on poor children will ignore the problems of children in higher income families.

ii) Universality - this principle including equal access, equal participation, and "equitable outcomes" (ie: same range of outcomes for all children, not necessarily equal outcomes).

iii) First five years - importance of early years for healthy brain development.

iv) Strategies for delivering the programme - eg: "civic community" where all children have the right to full participation in community life.

Another aspect of disadvantage is malnutrition. A standard definition of malnutrition often used is height or length for age more than two standard deviations below median of National Centre for Health Statistics/World Health Organisation reference population (WHO 1983). Using this definition, malnutrition is as much as 60% in under five year olds in Bangladesh, for example (Drewett 1996).

Malnutrition is not only associated with poor growth and subsequent mortality, but also enduring effects on cognitive development (Drewett 1996). For example, in an inner city study in Britain, children classed as below the 10th centile for both weight and height (ie: lowest 10% of the population) had an average IQ of 20 points lower than the control group at 4 years old (Skuse et al 1994).

While in a study of Embu toddlers in Kenya, animal protein intake at thirty months predicted "cognitive competence" at five years old (Sigman et al 1991).

The Worldwatch Institute report "State of the World 2004" (quoted in Cameron 2004) noted some of the imbalances in the world system. For example, they estimated that the elimination of hunger and malnutrition would cost 19 billion dollars, clean drinking water for all 10 billion dollars, and universal literacy 5 billion dollars. This compares with 18 billion dollars spent on make-up and 15 billion dollars on perfumes worldwide, and 17 billion dollars spent on pet food in Europe and the US.

CHILDREN LIVING IN ARMED CONFLICT SITUATIONS

Many children around the world are living in

situations of armed conflict and war. This situation clearly has consequences for the children.

For example, 88% of Iraqi children had Post-Traumatic Stress Disorder one year after experiencing bombing while in a shelter during the Gulf War, and 79% two years after the event (Karam and Bou Ghosa 2003).

Somasundaram (2002) has studied children in the civil war in North East Sri Lanka, both those who become child soldiers and schoolchildren generally. Of a group of over 600 adolescents in Vaddukoddai (North Sri Lanka), each child had experienced an average of four war-related stressors, like detention, displacement, or witnessed violence. Thirty-one per cent of the adolescents were diagnosed as having Post-Traumatic Stress Disorder and 21% depression.

Among 305 younger schoolchildren in the same area of Sri Lanka, the biggest problems were sleep disturbances (88%), separation anxiety (40%), and hyperalertness (50%).

This study also looked at the recruitment of child soldiers in the North East Sri Lankan civil war. Two main groups of causes were outlined:

i) Push factors - for example, brutalisation of children by Sinhala security forces (15% of 600 disappearances in 1996 in Jaffna were children); deprivation - families encourage children to join to guarantee the children food as a soldier;

ii) Pull factors - for example, a shortage of older men; the construction of a "martyr culture".

Thabet et al (2002) assessed 91 Palestinian children exposed to home bombardment and demolition during the Al Aqsa Intifada, and 89 controls exposed to other political violence in Gaza. The data were collected in January and February 2001. The exposed group had greater levels of "severe" and "very severe" Post-Traumatic Stress Disorder compared to the controls (59% vs 25%). But the control group had more anticipatory anxiety, and cognitive expressions of distress.

While Bhutta (2002) has argued that children in Afghanistan in the last 25 years have experienced malnutrition and disease among the highest in the world, as well as death and injuries from landmines and artillery, and psychological scars.

CONCLUSION

Teicher (2002) has argued that child maltreatment leads to changes in the physiology of the brain ie

"permanent damage to the neural structure and function of the developing brain itself". So if I am arguing that the experiences of many children in the poorer countries is akin to deliberate maltreatment and abuse, then their brain development must be affected. This could account for why individuals in the poorer countries have trouble "succeeding" as adults, and thus why their countries remain poor.

This argument would suit individuals who like to blame the victims for their problems, and to suggest that the world is basically fair: "we are rich because we have earned it" etc.

The childhood experiences in poorer countries are different in the sense of the greater amount of unpleasant experiences, but not unique because children in the West also have bad experiences. Some children in the poorer countries are permanently scarred by these experiences, whereas others show incredible resilience and grow up relatively unaffected. The same is true in other situations - some individuals suffer negative effects of their childhood, others don't. The most important point is that psychology needs to study the experiences of children (and adults) all around the world, not just in the West, or primarily the US.

FOOTNOTES

1. Emery and Laumann-Billings (2002) explained the causes of child abuse and neglect using four levels of analysis:

- i) Individual characteristics of the perpetrator (eg: poor impulse control), and of the victim (eg: behaviour problems);
- ii) Immediate context eg: family stressors;
- iii) Broader ecological context eg: poverty;
- iv) Societal or cultural context eg: beliefs about socialisation of children, punishment, and the family.

More generally, Bronfenbrenner (1979; 1989) has used the ecological model to explain human development. The development of the child is influenced by three systems:

- i) Microsystems - those systems that the child directly experiences eg: family, school;
- ii) Exosystems - the child indirectly experiences these systems eg: parents' work and friends;
- iii) Macrosystem - eg: poverty, culture.

2. This study by Bachman and Scholenberg (1993) questioned 70 000 US high school students between 1985-9, and found that 46.5% of males and 38.4% of females worked more than 20 hours per week.

3. Much of the same material appears in "The Growing Child" (Bee 1995b), which has three pages on poverty in the US, and three pages on malnutrition and pregnancy.

4. Morice (1981) has distinguished four types of "non-capitalist" child labour:

- i) Work in the domestic unit;
- ii) Work in a situation of quasi-slavery - the child as well as their labour is "owned" by the master;
- iii) Work in a quasi-feudal situation - labour in exchange for food and lodging;
- iv) Commercial activities eg: street-vending.

5. There are problems of actually measuring (and defining) how many child labourers (under the age of fifteen) exist. Gulrajani (2000) quoted official Indian census figures of 17.58 million child workers (fourteen years or under) in 1985 (approximately 10% of the child population). This is probably much higher now.

While Alvim (2000) quoted the figure of over 7.6 million child and adolescent labourers in Brazil in 1990.

Table 3 shows the "official" work rates of 10-14 year olds in the highest countries as collected by the ILO in the 1990s. The figures are not without problems (Gendreau 2000).

COUNTRY	BOYS	GIRLS
Africa - Senegal	61.0	38.5
Latin America - El Salvador	30.7	12.4
Asia - Bangladesh	39.4	30.4
Europe - Portugal	5.2	5.2
Overall	15.7	11.5

(After Gendreau 2000)

Table 3 - Highest percentage work rates of 10-14 year olds based on "official" figures in the 1990s.

6. "Consumer capitalism" is based upon inevitable continuous economic growth (ie: selling more products and increasing profits each year), but this takes place in saturated markets (individuals have enough products) and thus requires more aggressive marketing techniques (Brewer 2001a).

7. "Global capitalism" or "globalisation" can mean many things, but here are some of the main characteristics (Brewer 2003):

- i) Control by rich countries of access to the natural resources of the poorer countries;
- ii) Monopolistic position of companies from rich countries (ie: multi-nationals);
- iii) Selective labour migration towards richer countries;
- iv) Multi-nationals beyond individual state control;
- v) Greater awareness of these phenomena through the growth of the media;
- vi) Changes in world inequality in wealth.

Amin (1997) saw global capitalism as based around five monopolies - technology; financial control of worldwide financial markets; monopolistic access to the planet's natural resources; media and communication; and monopolies over the weapons of mass destruction.

"These five monopolies, taken as a whole, define the framework within which the law of globalised value operates.. What results is a new hierarchy more unequal than ever before, in the distribution of income on a world scale, subordinating the industries of the peripheries and reducing them to the role of subcontracting" (p5).

8. Brewer (2004b) addressed the reality of "free market capitalism" as it exists today - for example, instead of perfect competition, "Competition is so imperfect that exceptional profits are commonly earned by exploiting either one's own oligopolistic power or others' oversights, omissions, and mistakes" (Hawken et al 1999 p264).

9. Bales (2002) estimated that 27 million people (children and adults) worldwide are in bonded labour or similar forms of "modern slavery".

10. Bales (2002) told this story:

"One young woman I met in northeastern Thailand, Siri, has a typical story. A woman approached her parents, offered to find their 14-year-old daughter a job, and advanced them 50 000 baht.. against her future income. The broker transferred Siri to a low-end brothel for twice that sum. When she tried to escape, her debt was doubled again. She was told to repay it, as well as a monthly rent of 30 000 baht, from her earnings of 100 baht per customer" (p72).

Shiri was subsequently controlled by a combination of threats about her parents, the cultural norms of Thai females as obedient and non-assertive, and religious beliefs that she deserved enslavement because of terrible sins in a past life.

11. One variation can be in the form of child sex workers (Black 1994).

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KEVIN BREWER

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Anti-Social Personality Disorder in Action: Richard Ramirez?

INTRODUCTION

Aggression and violence have always held great fascination within the realms of psychology, especially in the area of serial murder. Theories of why humans kill are rich in diversity, difficult to define, and are often in conflict with each other (eg: Hickey 1997).

However, anti-social personality disorder (APD) has often been used to explain why many individuals carry out the most appalling crimes (Gross 2001). None more so than in the case of serial murderer, Richard Ramirez, who displayed classic symptoms of the disorder.

Also known as "psychopathy", APD is one of ten recognised personality disorders according to DSM-IV (APA 1994) ⁽¹⁾⁽²⁾. All the personality disorders are based upon:

enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts (APA 2000 p685).

APD is distinguished by the complete lack of concern or empathy for others, and the abnormal tendency for uncontrollable violence.

ANTI-SOCIAL PERSONALITY DISORDER

APD was defined in DSM-IV as:

a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood (APA 1994 p645).

Diagnosis of APD using DSM-IV requires evidence of three or more behaviours from a list of seven (table 1). The more behaviours evident the more severe the condition.

According to researchers Hart and Hare (1996), 50-80% of adult male prison inmates met the DSM-IV criteria for APD, and although this study failed to include any female percentages, this is still a significant percentage, highlighting the importance of identification early on. However, this is easier said than done given the fact that most serial murderers are not diagnosed

until after they have been caught.

301.7 ANTI-SOCIAL PERSONALITY DISORDER

Three or more from following behaviours:

1. Illegal non-conformity
2. Deceitfulness
3. Impulsivity
4. Irritability and aggression
5. Reckless disregard for safety of self and others
6. Irresponsible behaviour
7. Lack of remorse

Diagnosis also requires evidence of the following:

- A. Enduring pattern of these behaviours that deviates markedly from cultural expectations
- B. Enduring pattern is inflexible and pervasive across situations
- C. Stable and long term patterns of behaviour
- D. Not due to substance abuse or general medical condition
- E. The individual is distressed by their behaviour
- F. Behaviour not caused by another mental disorder

(After APA 1994)

Table 1 - DSM-IV criteria for Anti-Social Personality Disorder.

RICHARD RAMIREZ

This brings us to the case of Richard Ramirez, sometimes better known as the "nightstalker", who is attributed with at least seventeen murders ⁽³⁾.

It all began in the early morning of June 28th 1984, in the small community of Glassel Park, Los Angeles, California. It wasn't designed to be what it became: the first in a series of murders of escalating brutality that threw the entire Los Angeles area into complete panic. It was a burglary, but the burglar, strung out on cocaine and secure in the belief that Satan would protect him, was a time bomb ready to explode.

He parked his car down the street and walked to the two-story apartment building. For no particular reason, he selected the home of seventy-nine-year-old Jennie Vincow. It was such a warm night that she had the window of her first floor apartment open. The gloved hands carefully removed the screen and opened the window wider. Quietly, he got into the apartment and moved toward the

bedroom.

Soundlessly, he looked through the drawers, but found nothing that he could turn into cash for drugs or sex. He was furious that the old woman had nothing of value for him to steal. He would take something anyway, something very precious to Jennie - her life. The thought of it excited him, he later reported, so he took out his hunting knife and plunged it into the breast of the sleeping woman. She screamed and tried to fight him off, but he kept stabbing her. Finally, with one hand over her mouth, he slit her throat from ear to ear, nearly decapitating her. He was so energised by the thrill that he stabbed her three more times in the chest.

At 13 years old Ramirez began to use drugs, starting with cannabis, then moving on to LSD, other hallucinogenic drugs and eventually cocaine. The combination of drugs and alcohol deepened his aggressive psychotic episodes fuelling his need to kill, and by the time he was 24 years old, he had been arrested for thirteen murders, five attempted murders, six rapes, three lewd acts on children, two kidnappings, three acts of forced oral copulation, four counts of sodomy, five robberies, and fourteen burglaries. He was convicted on forty-six of those counts on 20th September 1989.

On the day of sentencing, Richard Ramirez insisted on reading a statement he had prepared. His voice was loud and angry:

You don't understand me. You are not expected to.
You are not capable. I am beyond your experience.
I am beyond good and evil. I will be avenged.
Lucifer dwells in all of us...I don't believe in
the hypocritical, moralistic dogma of this so-called
civilised society...you maggots make me sick.
Hypocrites one and all...I don't need to hear all of
societies rationalizations. I've heard them all
before...legions of the night, night breed, repeat
not the errors of the night prowler and show no mercy (4).

CAUSES OF THE BEHAVIOUR

APD has been attributed to factors of a biological nature such as abnormalities of the frontal lobe and serotonin dysfunctions, as well as psychological and sociological factors that include poor parenting, physical and sexual childhood abuse, rejection, lack of love, high levels of stress, and drugs (Brewer 2000).

This corresponds with the synthesis model of aggression (Brewer 2003a) that explains violent acts of aggression in terms of psychological, sociological, and biological factors (5).

However, Ramirez can only be judged as a human being and as such, he was tried, convicted and sentenced to death. If we are able to look at Richard Ramirez as only a human being, we need to understand what made him who he became. Inherent biological and psychological traits may have caused him to commit the crimes, and further research based on individuals like him could prevent other human lives from being taken by such violent killers. Perhaps by locking Ramirez up for years of study instead of sending him to the gas chamber or electric chair, could help steer us towards earlier detection.

However, there is one other theory to contemplate. One that would no doubt cause much controversy, and that is whether some serial murderers, like Richard Ramirez, Ted Bundy or Jack the Ripper, aren't just a product of society or a victim of biological determinants, but really are born of pure evil working on behalf of the Devil. Because after all if there is a Son of God who is inherently good, it would only seem logical that there is also a Son of Satan who is inherently bad. If this is the case, God help us all.

FOOTNOTES

1. Psychiatrists make use of two main classification systems for mental disorders - the "Diagnostic and Statistical Manual of Mental Disorders" (DSM) in the USA, and the "International Classification of Diseases, Injuries, and Causes of Death - Mental Disorders Section" (ICD) by the World Health Organisation. Currently, DSM-IV-TR (APA 2000) and ICD-10 (WHO 1992) are in use.

2. The ten personality disorders in DSM-IV are paranoid, schizoid, schizotypal, anti-social, borderline, histrionic, narcissistic, avoidant, dependent, and obsessive-compulsive. ICD-10 has a slightly different list of personality disorders (Brewer 2003b).

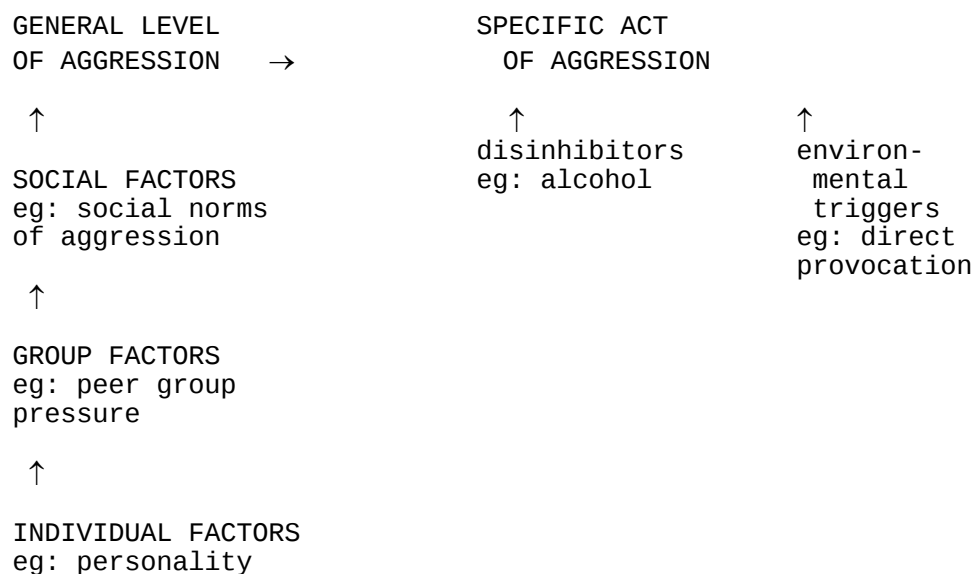
3. Information from http://www.shyscyberchamber.com/ramirez_richard.asp accessed 12/5/04 (table 2).

4. Quote from <http://roswell.fortunecity.com/seance /500 /killers> (accessed 12/05/04).

MURDER VICTIM	GENDER	DATE	METHOD OF KILLING
Jenni Vincow	female	28/6/84	stabbed
Dayle Okazaki	female	17/3/85	shot
Tsai Lian	female	17/3/85	shot
Vincent Zazzara	male	24/3/85	shot
Maxine Zazzara	female	24/3/85	shot/stabbed
William Doi	male	14/5/85	shot
Patty Elaine Higgins	female	27/6/85	throat cut
May Louise Cannon	female	2/7/85	throat cut
Joyce Lucille Nelson	female	7/7/85	beaten
Max Kneiding	male	20/7/85	shot
Lela Kneiding	female	20/7/85	shot
Chainarong Khovanath	male	20/7/85	shot
Christopher Peterson	male	5/8/85	shot
Virginia Peterson	female	5/8/85	shot
Elyas Abowath	male	8/8/85	shot
Peter Pan	male	17/8/85	shot
Barbara Pan	female	17/8/85	shot

Table 2 - Victims of Richard Ramirez.

5. Synthesis model of aggression (Brewer 2003a).



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Angela Walters

Article written May 2004

A Place for ECT?

INTRODUCTION

Despite the availability of many different anti-depressants ⁽¹⁾, McCall (2001) stated that electroconvulsive therapy (ECT) was still the most acutely effective treatment for depression, particularly depressive stupor, and catatonia ⁽²⁾. While Fink and Sackiem (1996) emphasised its benefits with schizophrenia.

Whether this is the case, the public perception of ECT is generally negative. This view may in part account for the decline in the use of ECT in recent years in Britain (Eranti and McLoughlin 2003) (table 1).

ENGLAND

1985	137 940 NHS administrations	
1991	105 466	
1999	65 930 (estimate)	5.8 patients per 100 000 total population

SCOTLAND

1992	2.85 treatments per 1000 population served in Edinburgh
1997	1.65

WALES

1990	39 patients per 100 000
1996	22

Table 1 - Figures showing the decline in use of ECT in Britain in recent years.

A decline in the use of ECT is evident in some parts of the US (eg: Herman et al 1995: no use in 100 metropolitan areas 1988-9), and in Europe. For example, ECT is prohibited in some cantons in Switzerland, and generally not used in Italy, Belgium and Germany (Eranti and McLoughlin 2003). Elsewhere use is also low; eg: Japan (Ishimoto et al 2000: 6% of patients in one university hospital 1975-97).

There are a number of factors that might explain the decline in the use of ECT:

- i) Public concern and negative perceptions of ECT;
- ii) Professional concern and the lack of consensus about its usefulness;

iii) Resource limitations - For example, a survey (Mental Health Act Commission 2001) of 230 ECT facilities in England and Wales in 2000-01 found that 20% of the centres were a long way from the "best practice" of "The ECT Handbook" guidelines (Royal College of Psychiatrists 1995). This study confirmed the picture of deficiency presented before by Pippard (1992), and Duffett and Lelliott (1998) with only one-third of ECT clinics surveyed meeting the Royal College of Psychiatrists' standards;

iv) Competition from other treatments (3);

v) The interest in alternative explanations for depression (and mental disorders generally) other than the mental illness (bio-medical) explanation. Consultant psychiatrist, Pat Bracken (2001) admitted:

Many people with experiences of depression had very low self-esteem which often stemmed from childhood. Some had complex social difficulties involving poverty, housing issues, racism and unemployment. Some had experienced bereavement which continued to weigh heavy and most continued to carry hurt caused by other people at some stage in their lives. I have come to believe that framing the sadness and misery associated with all these problems as primarily due to a problem with neurotransmitters is simply inadequate. For most people, attempting to deal with depression by changing brain chemistry is akin to someone trying to change the storyline of Eastenders by interfering with the wiring of their television set (p27).

QUALITY OF LIFE AND ECT

There are also professional concerns about the effects of ECT on memory, health, and quality of life. The National Institute for Clinical Excellence (NICE) (2003) recommended restricting the use of ECT, but only until better research findings are produced on its effects.

Whether ECT is successful in reducing depression must take into account the individual's subsequent quality of life after the treatment. Thus any benefits of relieving depression could be outweighed in terms of quality of life by side effects, particularly cognitive deficits (ie: memory).

Breggin (1991) was highly critical of ECT, and particularly the claims that it works:

To the extent that it works at all, shock has its

impact by disabling the brain. It does so by causing an organic brain syndrome, with memory loss, confusion, and disorientation, and by producing lobotomy effects. For a few days or weeks the patient may be euphoric or high as a result of the brain damage, and this may be experienced as "feeling better" (p245; quoted in Mills 2000).

Data from the California Department of Mental Health for 1989-92 and 1994 showed that 19.7% of 12 310 individuals who received ECT had memory loss of more than three months after the final treatment. This figure was 93.6% of those individuals with complications during ECT. Overall 21% of the total had some kind of problem during or after ECT (HealthyPlace.com).

McCall et al (2004) investigated post-ECT quality of life in seventy-seven depressed individuals in North Carolina. All participants were 18 years or older (mean age 57.3 years), had no evidence of schizophrenia, learning disability or neurological illness, and scored at least 20 on the Hamilton Rating Scale for Depression (HRSD) (Hamilton 1960; 1967) ⁽⁴⁾.

The HRSD was completed 1-3 days before the first ECT session, and two and four weeks after the last session. The number of ECT sessions varied between individuals. Cognitive assessments and quality of life measures were made at the same times as the completion of the HRSD. Only complete data for 41 participants were collected.

The sample showed significant improvements in mood, cognition, and quality of life at both two and four weeks after ECT. However, overall group differences did hide the fact that some individuals had worse quality of life scores after ECT. These individuals had lower depression scores before ECT, and greater memory deficits afterwards. For the researchers, the study shows how quickly improvements occur with ECT (ie: within two weeks after treatment).

As with many psychiatric studies on ECT, the results are in favour of its use. In this case, not only in reducing depression, but also in improving quality of life.

Mills (2000) was critical: "It is contended that misquoting of research is sometimes essential when psychiatrists wish to misrepresent ECT and other invasive treatments for purposes unrelated to the best interests of patients" (p10).

She also highlighted the problem that it is not clear how ECT works: "the likeliest mechanism of action for ECT is concussion.. If concussion saves lives, why not simply bang heads against walls and be done with it?" (p13).

Studies finding positive results for the use of ECT are contradicted by the experiences of the individuals themselves who have undergone the treatment ⁽⁵⁾.

It would be wrong to say that no one can or has ever benefited from ECT, but there are issues relating to the psychiatric studies which should mean reservations exist over their positive conclusions.

1. Specific methodological problems: McCall et al (2004)

a) McCall et al (2004) admitted that their sample size was "modest" (41 participants), and that the period of follow-up was only one month. However, other studies by McCall have found continued improvements one year after ECT (eg: McCall et al 2001).

b) The measurement of depression was based upon the Hamilton Rating Scale for Depression as part of a semi-structured interview, and the self-administered Beck Depression Inventory (BDI) (Beck et al 1961; 1988). Other measurements, like quality of life, were self-administered: eg Daily Living and Role Functioning (DLRF) sub-scale of the Basis-32 Questionnaire (Eisen et al 1994).

Self-administered questionnaires have a number of problems:

i) The wording of the questions influences the responses given; eg: offering the response alternative "satisfied" gets different answers to offering "dissatisfied" (Brewer 2002) ⁽⁶⁾;

ii) The respondent may misunderstand the question;

iii) The answers depend upon the honesty of the respondent, which can be influenced by memory errors, lies, or socially desirable answers.

2. General methodological problems of psychiatric studies

a) Placebo Effect - Part of any treatment will be a placebo effect. This is an improvement in health due to the expectations of the benefits rather than the actual treatment (Brown 1998). It has been suggested that a large percentage of any improvement through a treatment is due to the placebo effect; eg: 75% of the effect of antidepressants (Kirsch and Sapirstein 1998). The placebo effect can be seen as the power of the expectations and suggestions of others.

b) Hope - Similar to the placebo effect is the desire to get better of the depressed individual. Individuals who undergo ECT will want to feel better afterwards, and thus believe that their depression is reduced. This factor can be distinguished as the power of self-expectations or self-suggestion.

For most researchers, the placebo effect includes hope as well (Walach 2003). Most recent definitions of the placebo effect place emphasis on the meaning of the treatment for the individual (eg: Moerman and Jonas 2002).

c) Cognitive dissonance - This is an explanation put forward by Festinger (1957) to account for attitude changes. When two "cognitions" are inconsistent, the individual is motivated to resolve this.

A well-known example is of a smoker who believes that "smoking causes cancer". This is a situation of inconsistency, which Festinger argued causes "psychological discomfort". The "sensible" option would be to stop smoking, but that is fixed, so the individual must change their attitudes about "smoking causes cancer".

This can be done in a number of ways:

- By belittling the evidence about smoking and cancer;
- Convincing others to smoke;
- Building an image around no fear of cancer;
- Smoking low-tar cigarettes;
- Associating with other smokers.

Another example of cognitive dissonance is the situation where individuals do something in order to gain a reward, but the reward is then not given after the individual has done that task. This causes inconsistency: the individual worked for the reward, but there was no reward.

The fact that the individual worked for the reward cannot be changed, so the motivation is what can be changed. The individual comes to believe that they worked for their own satisfaction, and so subsequently are more enthusiastic about the task now there is no reward. What this shows is that individuals are quite illogical in their behaviour (Brewer 2003).

While if individuals voluntarily perform a behaviour that is opposite to the attitudes held, this also produces cognitive dissonance.

Festinger and Carlsmith (1959) had participants doing a boring task, and then convincing others that the task was interesting. The participants were paid either 1 or 20 dollars for convincing others. The group paid 1

dollar suffered cognitive dissonance. They had done the boring task then convinced others of its interest, therefore cognitive dissonance produced a change in their attitude; ie: they came to believe that the task was not that boring.

Applying these ideas to the situation of ECT and improvements in mood, there is an inconsistency between undergoing the ECT and the negative after-effects, which the individual resolves as feeling better (figure 1).

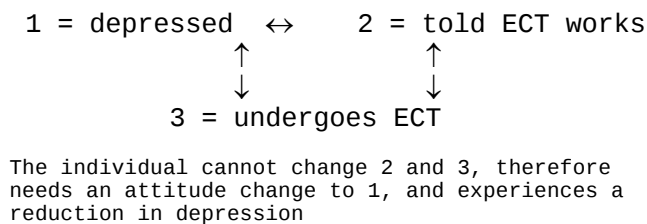


Figure 1 - Cognitive dissonance and improvements in mood after ECT.

Cognitive dissonance can be applied to therapy as well, particularly where individuals have paid a lot of money for it. For example, "I have paid all that money, so I must be getting better".

d) "Hello-Goodbye Effect" - This is a situation that can occur with any form of treatment or therapy. At the beginning of the treatment, the individual exaggerates the severity of the problem ("hello"), and then exaggerates the success of the treatment at the end ("goodbye") (Rosenhan and Seligman 1995).

AUDIT OF ECT CLINICS

Whether ECT reduces depression or not is a debate that will not go away, but it can be academic compared to the reality of ECT clinics. The Royal College of Psychiatrists has proposed guidelines for the use of ECT (1977; 1989; 1995), and subsequently instigated audits of ECT clinics in Britain in 1981 (Pippard and Ellam 1981), 1992 (Pippard 1992), and 1995-6 (Duffett and Lelliott 1998). Other studies have also been carried out (eg: Mental Health Act Commission 2001).

1st audit (Pippard and Ellam 1981)

This involved visiting 180 ECT clinics in the UK. The main findings were the continued use of obsolete

machines, and poor training of junior doctors for ECT.

2nd audit (Pippard 1992)

This smaller study only involved 35 NHS and five private ECT clinics in the North East Thames and East Anglia regions. Despite improvements, the same problems as the first audit were evident.

3rd audit (Duffett and Lelliott 1998)

This larger study involved two parts: (i) visits to 33 NHS and five private ECT clinics in the North East Thames and East Anglia regions, and 17 in Wales; and (ii) questionnaires received from 129 of 165 ECT clinics in England.

The main findings can be summarised as follows:

a) ECT clinics as a whole - 13% were rated as "poor" and 54% "deficient in some areas" based on the Royal College of Psychiatrists (1995) guidelines (7);

b) ECT machinery - 7% of the clinics were still using ECT machines no longer recommended by the Royal College in 1989 because "older machines are underpowered, deliver a very restricted range of current and do not record the current actually delivered" (Duffett and Lelliott 1998 p402). While 108 clinics (59%) had one of the four recommended "state of the art" machines (8);

c) Staff - The quality varied between clinics: though consultant psychiatrists were named as responsible for the ECT clinic some attended regularly (16% once a week), others not (9% of clinics visited). In four clinics visited, anaesthetic input was rated as poor due to lack of experience of staff, while 68% overall had consultant anaesthetists for at least one session per week;

d) Clinics visited - Richard Duffett visited the 55 clinics, and admitted that "had he required it, he would have been reluctant to receive ECT in thirteen of the clinics visited (24%)" (Duffett and Lelliott 1998 p403). Table 2 shows a summary of the ratings of the visited clinics.

RATED AS POOR

RATED AS GOOD*

ECT suite	25.5	25.5
ECT/anaesthetic equipment	9	34
Psychiatric staff	18	20
Anaesthetic staff	7	37
Nursing staff	20	38

* remainder rated as average
(After Duffett and Lelliott 1998)

Table 2 - The percentage of ECT clinics receiving good or poor ratings on five criteria.

e) Overall - One-third of ECT clinics in England and Wales could be regarded as good, or put another way, two-thirds "fall short of the most recent College standards" (Duffett and Lelliott 1998 p405).

CONCLUSION

There will always be supporters of the use of ECT, like Fink (eg: 1979) in the US, or a British psychiatrist quoted in Wise (1997) who saw it as "under-used" and "remarkably safe".

The debate about the use of ECT has and will remain entrenched between ardent supporters (usually psychiatrists), and those against it (usually "survivors of the mental health system"). Unfortunately, ECT is associated with too many negative aspects to remove the public concern, and these aspects include:

i) The fact that ECT is the deliberate inducing of a seizure, which Breggin (1991) called "fundamentally electrical head injury";

ii) The lack of knowledge of how ECT actually works in the brain to reduce depression. There are theories relating to biochemical changes. Whereas many individuals report ECT as punishment for their unhappiness or for being different (Brewer 2001);

iii) Its misuse with the young (eg infants: Jones and Baldwin 1996), and with the old (eg 92 years old: Cobb 1993);

iv) The bias in use towards certain groups, like women: 68% of individuals receiving ECT in California in 1989-92 and 1994 (HealthyPlace.com). Women are generally twice as likely to receive ECT than men in Britain (Cobb 1993);

- v) The side effects;
- vi) The problems with ECT clinics;
- vii) ECT is often recommended for drug-resistant depressed individuals, but it does not necessarily work for them (Prudic 1996);
- viii) The administration of ECT without the consent, or with the "forced consent" of individuals.

With all the progress of medical science and technology, it must be possible to find a better way to help individuals with depression than with ECT. Bracken (2001) described the attempt in the Bradford Home Treatment Service to break away from the dominance of the biomedical model of psychiatry:

We attempted to encounter depression as a "site of struggle" rather than as an illness, and offer to struggle for a solution alongside the individual in question. It is my belief that this opens up different ways of understanding the reasons behind depression and different ways of going forward (p28).

Thus the way to deal with the use of ECT is to deal with the biomedical model of psychiatry.

FOOTNOTES

1. There are approximately thirty different types of antidepressants available in the UK (Cheeta et al 2004).
2. In a survey of consultant psychiatrists in north west England, Benbow et al (1998) found that two-thirds saw ECT as the treatment of choice for "depressive illness with high suicidal risk", and 89% for "depressive illness with refusal to eat".
3. For example, by 2002 36 million people worldwide had taken the antidepressant "Prozac" ("In Pills We Trust: Better Than Well" 2002; Discovery Channel).
4. Hamilton Rating Scale for Depression measures the severity of depression based on 21 items (originally 17 items) during a semi or unstructured interview. A score of 20 or more is often used as a measure of depression in studies (eg: McCall et al 2004).
5. Support and campaign groups have been set up to help individuals after bad experiences of ECT: eg "ECT

Anonymous" in the UK. One of the founders, Jean Taylor, received ECT more than fifty times in a ten-year period up to 1993, mostly without her consent (Brewer 2001).

In a survey, 89% of MIND members wanted ECT banned ("Case Notes" 1999; BBC Radio 4). The main issue for individuals who have undergone ECT is that it can be given without the need for their consent under the Mental Health Act 1983.

6. Diana Rose of the Service User Research Unit (SURE) noted that the way the questions are asked and by whom is important. Research by SURE found that at least 30% of individuals had specific episode permanent memory loss after ECT ("All in the Mind" 2003; BBC Radio 4).

7. Examples of guidelines from Royal College of Psychiatrists (1995) (quoted in Duffett and Lelliott 1998):

ECT suites should consist of separate waiting room, treatment room and recovery room, and be warm, clean and of an adequate size.

Consultant psychiatrist should attend the clinic regularly and be acquainted with College recommendations on ECT practice.

Junior doctors should observe ECT being given before they administer it themselves and should be supervised for the first few treatments they administer by a psychiatrist.

8. One of the recommended machines, which 11% of ECT clinics used, was produced by the MECTA Corporation. Butterfield and Doherty (1999) reported the case, in the US, of Imogene Robovit who received a settlement from MECTA Corporation over safety problems with the machine. Imogene Robovit was suing the company for brain damage and being rendered unfit to work because of ECT.

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KEVIN BREWER

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